FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026914

Facility Name: CONCORD EXTENDED CARE

Address: 9401 SOUTH RIDGELAND (Number) OAK LAWN (City) 60453 (Zip Code)

County: COOK

Telephone Number: (708) 449-9090 **Fax #** (708) 449-7070

IDPA ID Number: 362833027001

Date of Initial License for Current Owners: 00/00/67

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) EDWARD N. SLACK, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	134	Skilled (SNF)	134	48,910	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	48,910	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,470	419	2,149	5,038	8
9	SNF/PED					9
10	ICF	27,589	11,386	765	39,740	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,059	11,805	2,914	44,778	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.55%

D. How many bed-hold days during this year were paid by Public Aid?
228 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1962

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 1980

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	187,924	23,114	13,984	225,022		225,022	(2,600)	222,422			1
2	Food Purchase		164,119		164,119	(15,914)	148,205	469	148,674			2
3	Housekeeping	191,734	28,880		220,614		220,614	1,392	222,006			3
4	Laundry	66,595	20,508		87,103		87,103	(4,969)	82,134			4
5	Heat and Other Utilities			99,387	99,387		99,387	1,845	101,232			5
6	Maintenance	58,487		60,649	119,136		119,136	8,393	127,529			6
7	Other (specify):*							1,506	1,506			7
8	**TOTAL General Services**	504,740	236,621	174,020	915,381	(15,914)	899,467	6,036	905,503			8
	B. Health Care and Programs											
9	Medical Director			5,444	5,444		5,444		5,444			9
10	Nursing and Medical Records	1,567,602	60,321	89,813	1,717,736		1,717,736	10,357	1,728,093			10
10a	Therapy	42,467	1,501	12,427	56,395		56,395	44	56,439			10a
11	Activities	81,086	6,118	4,621	91,825		91,825	(707)	91,118			11
12	Social Services	49,210		761	49,971		49,971	754	50,725			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							10,930	10,930			15
16	**TOTAL Health Care and Programs**	1,740,365	67,940	113,066	1,921,371		1,921,371	21,378	1,942,749			16
	C. General Administration											
17	Administrative			216,520	216,520		216,520	33,576	250,096			17
18	Directors Fees											18
19	Professional Services			273,263	273,263		273,263	(190,499)	82,764			19
20	Dues, Fees, Subscriptions & Promotions			46,016	46,016		46,016	(28,694)	17,322			20
21	Clerical & General Office Expenses	101,719	21,333	84,761	207,813		207,813	35,207	243,020			21
22	Employee Benefits & Payroll Taxes			368,010	368,010	15,914	383,924	(27,704)	356,220			22
23	Inservice Training & Education			476	476		476		476			23
24	Travel and Seminar			3,240	3,240		3,240	79	3,319			24
25	Other Admin. Staff Transportation			6,509	6,509		6,509	(5,371)	1,138			25
26	Insurance-Prop.Liab.Malpractice			99,363	99,363		99,363	945	100,308			26
27	Other (specify):*							23,595	23,595			27
28	**TOTAL General Administration**	101,719	21,333	1,098,158	1,221,210	15,914	1,237,124	(158,867)	1,078,257			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,346,824	325,894	1,385,244	4,057,962		4,057,962	(131,453)	3,926,509			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CONCORD EXTENDED CARE #0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			128,435	128,435		128,435	2,611	131,046			30
31	Amortization of Pre-Op. & Org.			2,837	2,837		2,837		2,837			31
32	Interest			98,967	98,967		98,967	3,013	101,980			32
33	Real Estate Taxes			150,589	150,589		150,589	2,677	153,266			33
34	Rent-Facility & Grounds							3,674	3,674			34
35	Rent-Equipment & Vehicles			4,133	4,133		4,133	2,770	6,903			35
36	Other (specify):*											36
37	**TOTAL Ownership**			384,961	384,961		384,961	14,745	399,706			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,322	133,440	229,762		229,762	(2,156)	227,606			39
40	Barber and Beauty Shops			31	31		31		31			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,365	73,365		73,365		73,365			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		96,322	206,836	303,158		303,158	(2,156)	301,002			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,346,824	422,216	1,977,041	4,746,081		4,746,081	(118,864)	4,627,217			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,612)	30		9
10	Interest and Other Investment Income	(4,547)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(430)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	21		24
25	Fund Raising, Advertising and Promotional	(13,227)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,217)	20		28
29	Other-Attach Schedule	(10,876)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,909)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(58,956)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (58,956)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (118,864)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CONCORD EXTENDED CARE

ID# 0026914

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collection Expense	$ (743)	21	1
2	Jury Duty	(34)	10	2
3	Laundry Income	(4,969)	04	3
4	COPE ILLTC - Political Donation	(2,456)	20	4
5	Legal Invoice	(603)	19	5
6	Legal Invoices (Prior Year)	(1,176)	19	6
7	Seminar Expense (Unaccounted Invoices)	(895)	24	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			3,560	(4,854)		(1,306)						(2,600)	1
2	Food Purchase	(430)		(335)			1,233						469	2
3	Housekeeping			1,392									1,392	3
4	Laundry	(4,969)											(4,969)	4
5	Heat and Other Utilities			1,845									1,845	5
6	Maintenance			10,221	(1,828)								8,393	6
7	Other (specify):*			1,443			63						1,506	7
8	**TOTAL General Services**	(5,399)		18,127	(6,683)		(10)						6,036	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)		20,858	(65,255)	58,197	12	(3,421)					10,357	10
10a	Therapy			4,158	(4,114)								44	10a
11	Activities			1,610	(2,317)								(707)	11
12	Social Services			1,515	(761)								754	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,578		7,352							10,930	15
16	**TOTAL Health Care and Programs**	(34)		31,719	(72,447)	65,549	12	(3,421)					21,378	16
	C. General Administration													
17	Administrative			33,546	(74,111)	74,111	30						33,576	17
18	Directors Fees													18
19	Professional Services	(1,779)		4,917	(193,643)		6						(190,499)	19
20	Fees, Subscriptions & Promotions	(17,900)		1,339	(12,136)		3						(28,694)	20
21	Clerical & General Office Expenses	(24,743)		96,207	(36,310)		53						35,207	21
22	Employee Benefits & Payroll Taxes				(27,704)								(27,704)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(895)		974									79	24
25	Other Admin. Staff Transportation			52	(5,484)		61						(5,371)	25
26	Insurance-Prop.Liab.Malpractice			945									945	26
27	Other (specify):*			14,584		9,011							23,595	27
28	**TOTAL General Administration**	(45,317)		152,564	(349,389)	83,122	153						(158,867)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,750)		202,410	(428,519)	148,671	155	(3,421)					(131,453)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,612)		7,223									2,611	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,547)		7,559			1						3,013	32
33	Real Estate Taxes			2,677									2,677	33
34	Rent-Facility & Grounds			3,674									3,674	34
35	Rent-Equipment & Vehicles			2,767			3						2,770	35
36	Other (specify):*													36
37	TOTAL Ownership	(9,159)		23,900			4						14,745	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(756)	(1,400)					(2,156)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(756)	(1,400)					(2,156)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(59,909)		226,310	(428,519)	148,671	(597)	(4,821)					(118,864)	45

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 3,560	$ 3,560	15
16	V	2	FOOD				(335)	(335)	16
17	V	3	HOUSEKEEPING				1,392	1,392	17
18	V	5	UTILITIES				1,845	1,845	18
19	V	6	REPAIRS AND MAINT.				10,221	10,221	19
20	V	7	EMP. BEN. - GEN. SERV.				1,443	1,443	20
21	V	10	NURSING				20,858	20,858	21
22	V	10A	THERAPY				4,158	4,158	22
23	V	11	ACTIVITIES				1,610	1,610	23
24	V	12	SOCIAL SERVICES				1,515	1,515	24
25	V	15	EMP. BEN. - HEALTHCARE				3,578	3,578	25
26	V	17	ADMINISTRATIVE				33,546	33,546	26
27	V	19	PROFESSIONAL FEES				4,917	4,917	27
28	V	20	DUES, SUBSCRIPTIONS				1,339	1,339	28
29	V	21	CLERICAL AND GENERAL				96,207	96,207	29
30	V	24	SEMINARS				974	974	30
31	V	25	AUTO EXPENSE				52	52	31
32	V	26	INSURANCE				945	945	32
33	V	27	EMP. BEN. - GEN. ADMIN.				14,584	14,584	33
34	V	30	DEPRECIATION				7,223	7,223	34
35	V	32	INTEREST				7,559	7,559	35
36	V	33	REAL ESTATE TAXES				2,677	2,677	36
37	V	34	BUILDING RENT - UNRELATED				3,674	3,674	37
38	V	35	EQUIPMENT RENTAL				2,767	2,767	38
39	Total			$			$ 226,310	$ * 226,310	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 4,854	CARE CENTERS, INC.	100.00%	$	$ (4,854)	15
16	V	19	ACCOUNTING	15,000				(15,000)	16
17	V	19	ANCIL ADMIN FEE	15,960				(15,960)	17
18	V	19	BOOKEEPING	27,132				(27,132)	18
19	V	19	DATA PROCESSING	4,788				(4,788)	19
20	V	19	LEGAL	12,043				(12,043)	20
21	V	19	MANAGEMENT FEE	111,720				(111,720)	21
22	V	19	PROFESSIONAL FEES	7,000				(7,000)	22
23	V	20	ADVERTISING	12,136				(12,136)	23
24	V	25	REBILL BUS	5,484				(5,484)	24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	27,704				(27,704)	26
27	V	1	REBILL. PAYROLL DIETARY						27
28	V	3	REBILL. PAYROLL HSKPNG						28
29	V	6	REBILL. PAYROLL MAINT.	1,828				(1,828)	29
30	V	10	REBILL. PAYROLL NURSING	65,255				(65,255)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	4,114				(4,114)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	2,317				(2,317)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	761				(761)	33
34	V	17	REBILL. PAYROLL ADMIN.	74,111				(74,111)	34
35	V	21	REBILL. PAYROLL CLERICAL	36,310				(36,310)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 428,519			$	$ * (428,519)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 58,197	$ 58,197	15
16	V	15	EMP. BEN HEALTHCARE				7,352	7,352	16
17	V	17	ADMINISTRATIVE				74,111	74,111	17
18	V	27	EMP. BEN GEN. ADMIN.				9,011	9,011	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 148,671	$ * 148,671	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 697	$ 697	15
16	V	2	FOOD				1,233	1,233	16
17	V	6	MAINTENANCE						17
18	V	7	EMP. BEN. - GEN. SERV.				63	63	18
19	V	10	NURSING				12	12	19
20	V	17	ADMINISTRATIVE				30	30	20
21	V	19	PROFESSIONAL FEES				6	6	21
22	V	20	DUES, FEES, SUB.				3	3	22
23	V	21	CLERICAL & GENERAL				53	53	23
24	V	24	SEMINARS						24
25	V	25	TRAVEL				61	61	25
26	V	32	INTEREST				1	1	26
27	V	35	RENT - EQUIPMENT & VEHICLES				3	3	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				40	40	28
29	V	1	DIETARY SUPP	2,003				(2,003)	29
30	V	39	ANCILLARY SUPP	796				(796)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,799			$ 2,202	$ * (597)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 27,963	$ 27,963	15
16	V	39	ANCILLARY SUPPLIES				11,530	11,530	16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	31,384				(31,384)	19
20	V	39	ANCILLARY SUPPLIES	12,930				(12,930)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 44,314			$ 39,493	$ * (4,821)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 99,926	$ 99,926	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	99,926				(99,926)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 99,926			$ 99,926	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Noah Wolff	Owner	Administrative	16.00%	See Attached	11.00	26.19%	Mgmt Fees	$ 71,204	17-3	1
2	Eric Rothner	Owner	Administrative	33.00%	See Attached	1.44	2.00%	Mgmt Fees	71,204	17-3	2
3	Mark Steinberg	Relative	Administrative	0.00	See Attached	1.47	2.94%	Salary Alloc	1,307	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 143,715		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	44,778	$ 3,560	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		44,778	(335)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	44,778	1,392	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		44,778	1,845	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	44,778	10,221	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		44,778	1,443	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	44,778	20,858	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	44,778	4,158	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	44,778	1,610	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	44,778	1,515	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		44,778	3,578	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	44,778	33,546	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		44,778	4,917	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		44,778	1,339	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	44,778	96,207	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		44,778	974	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		44,778	52	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		44,778	945	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		44,778	14,584	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		44,778	7,223	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		44,778	7,559	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		44,778	2,677	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		44,778	3,674	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		44,778	2,767	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 226,310	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CARE CENTERS, INC.
Street Address 150 FENCL LANE
City / State / Zip Code HILLSIDE, IL. 60162
Phone Number (708)449-9090
Fax Number (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296		58,197	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011			7,352	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		74,111	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			9,011	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 148,671	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,322,899	28	578,157	413,013	2,799	697	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,322,899	28	1,023,347		2,799	1,233	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,322,899	28	185		2,799		3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,322,899	28	52,590		2,799	63	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,322,899	28	9,570		2,799	12	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,322,899	28	25,000		2,799	30	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,322,899	28	4,819		2,799	6	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,322,899	28	2,196		2,799	3	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,322,899	28	43,980		2,799	53	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,322,899	28	257		2,799		10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,322,899	28	50,512		2,799	61	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,322,899	28	801		2,799	1	12
13	35	RENT - EQUIPMENT & VEHICI	HEALTH SYSTEMS INC.	2,322,899	28	2,624		2,799	3	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,322,899	28	33,430		2,799	40	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,827,468	$ 413,013		$ 2,202	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 27,963	1
2	39	ANCILLARY SUPPLIES	DIRECT ALLOCATION						11,530	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 39,493	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 99,926	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 99,926	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIB Bank		X	Mortgage Loan	$31,975	10/10/99	$ 1,000,000	$ 970,441	09/04	8.25%	$ 81,831	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Diawa Loan	X		Working Capital		03/01/01		387,947	03/01/02		16,435	6
7				Insurance Financing							701	7
8												8
9	TOTAL Facility Related				$31,975		$ 1,000,000	$ 1,358,388			$ 98,967	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	CCI Allocation										7,560	11
12	Interest Income										(4,547)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,013	14
15	TOTALS (line 9+line14)						$ 1,000,000	$ 1,358,388			$ 101,980	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	140,454	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	144,649	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,195	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	149,071	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	153,266	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	122,793	8
	1997	125,056	9
	1998	125,208	10
	1999	133,766	11
	2000	141,972	12

2001 Accrual-141,972*1.05=149,070

CCI Allocation - $2,677

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CONCORD EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0026914

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE 847-236-1111 FAX #: 847-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-05-302-003-0000	Long Term Care Property	$ 141,971.70	$ 141,971.70
2.			$	$
3.	Care Center, Inc.	Facility Allocation	$ 66,986.83	$ 1,970.30
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 208,958.53	$ 143,942.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,133 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 2,837 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	56,110	1962	$ 27,417	1
2	Related Party Alloc		1996	1,882	2
3	TOTALS	56,110		$ 29,299	3

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1962	$ 339,532	$		$	$	$ 339,532	4
5				1987	1,493,264	50,341	35	47,405	(2,936)	618,559	5
6				1962	112,250						6
7											7
8											8
	Improvement Type**										
9	Various			1974	1,435			-		1,435	9
10	Various			1976	4,663			-		4,663	10
11	Various			1977	2,336			-		2,336	11
12	Various			1978	765			-		765	12
13	Various			1980	33,145			-		33,145	13
14	Various			1982	2,378			-		2,292	14
15	Various			1983	45,375			1,815	1,815	32,711	15
16	Various			1984	21,344			853	853	14,006	16
17	Various			1985	14,833			742	742	11,872	17
18	Various			1986	16,300			815	815	12,225	18
19	Various			1988	41,219			1,662	1,662	22,784	19
20	Various			1989	3,324			166	166	2,045	20
21	Various			1990	8,400			420	420	4,655	21
22	Various			1991	34,006			1,702	1,702	18,362	22
23	Various			1992	8,695			435	435	4,069	23
24	Various			1993	11,679			585	585	5,080	24
25	Various			1994	29,410			1,472	1,472	11,114	25
26	Various			1995	118,494			5,927	5,927	37,404	26
27	Various			1996	68,945			3,449	3,449	18,043	27
28	Various			1997	54,013			2,701	2,701	12,019	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		42,032	1,109		1,411	302	6,956	68
69	Financial Statement Depreciation			19,693			(19,693)		69
70	TOTAL (lines 4 thru 69)		$ 2,507,837	$ 71,143		$ 71,560	$ 417	$ 1,216,072	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,507,837	$ 71,143		$ 71,560	$ 417	$ 1,216,072	1
2	Painting & decoratin	1998	6,688			334	334	1,113	2
3	DRYWALL	1998	795			40	40	160	3
4	PLUMBING RENOV	1998	800			40	40	157	4
5	NURSE CALL SYS.	1998	1,905			95	95	372	5
6	HVAC RENOV	1998	717			36	36	141	6
7	DRAPES	1998	6,552			328	328	1,257	7
8	PAINTING	1998	1,000			50	50	192	8
9	LIGHTING	1998	921			46	46	176	9
10	HVAC RENOV	1998	1,120			56	56	210	10
11	WALL COVERING	1998	3,173			159	159	583	11
12	HVAC RENOV	1998	2,258			113	113	414	12
13	FIRE SYS.UPGRADE	1998	5,172			259	259	950	13
14	DOORS	1998	3,976			199	199	730	14
15	PLUMBING RENOV.	1998	5,853			293	293	1,074	15
16	ASPHALT	1998	14,318			716	716	2,566	16
17	HVAC RENOV	1998	6,273			314	314	1,125	17
18	PAINTING	1998	746			37	37	133	18
19	SEWER LINE	1998	780			39	39	140	19
20	PLASTER	1998	1,200			60	60	215	20
21	LANDSCAPING	1998	1,147			57	57	204	21
22	ROOFING	1998	2,300			115	115	412	22
23	SEWER REPAIR	1998	745			37	37	133	23
24	FIRE SYS RENOV	1998	1,420			71	71	249	24
25	WALLCOVERING	1998	525			26	26	91	25
26	SEAL COAT	1998	1,079			54	54	189	26
27	DRAPERIES	1998	11,381			569	569	1,992	27
28	LAMINATE TOPS	1998	7,105			355	355	1,243	28
29	PLUMBING RENOV	1998	545			27	27	95	29
30	WANDERER SYS	1998	5,804			290	290	991	30
31	CARPETING	1998	5,250			263	263	899	31
32	ART	1998							32
33	WALL COVERING	1998	4,885			244	244	813	33
34	TOTAL (lines 1 thru 33)		$ 2,614,270	$ 71,143		$ 76,882	$ 5,739	$ 1,235,091	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,614,270	$ 71,143		$ 76,882	$ 5,739	$ 1,235,091	1
2	PLASTER	1998	750			38	38	127	2
3	DRAPES	1998	2,279			114	114	371	3
4	BED SPREADS	1998							4
5	DOORS	1998	37,625			1,881	1,881	5,957	5
6	SPRINKLER HEADS	1998	1,420			71	71	219	6
7	FLUSH METAL DOORS	1998	4,660			233	233	718	7
8	PHONE SYSTEM	1998	5,484			274	274	1,233	8
9	HOSES	1999	807			40	40	120	9
10	ART WORK	1999							10
11	VALUES	1999	710			36	36	108	11
12	UTILITY ROOM WORK	1999	6,087			304	304	912	12
13	TILES FOR LOUNGE	1999	5,625			281	281	843	13
14	FOUNTAINS	1999	839			42	42	126	14
15	CW ENERGY SAVER	1999	590			30	30	90	15
16	PAINT	1999	822			41	41	123	16
17	DOOR KNOB	1999	547			27	27	77	17
18	LOCK & DOOR HANDLES	1999	1,840			92	92	253	18
19	FIRE ALARM REPAIR	1999	633			32	32	88	19
20	FIRE ALARM REPAIR	1999	1,443			72	72	198	20
21	FIRE ALARM REPAIR	1999	2,048			102	102	281	21
22	FLOWER PLATTING	1999	1,286			64	64	165	22
23	HINGES	1999	6,375			319	319	798	23
24	FABRIC	1999	722			36	36	84	24
25	DRAPES	1999	1,843			92	92	207	25
26	NURSE CALL	1999	830			42	42	167	26
27	ALARM DETERRANT	1999	607			30	30	111	27
28	TRANSMITTER	1999	712			36	36	131	28
29	FAUCET	1999	1,297			65	65	228	29
30	PLUMBING SUPPLIES	1999	753			38	38	132	30
31	VINYL LOUVER	1999	666			33	33	105	31
32	FANS	1999	684			34	34	108	32
33	FANS	1999	612			31	31	98	33
34	TOTAL (lines 1 thru 33)		$ 2,704,866	$ 71,143		$ 81,412	$ 10,269	$ 1,249,269	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,704,866	$ 71,143		$ 81,412	$ 10,269	$ 1,249,269	1
2	FANS	1999	1,074			54	54	162	2
3	CARPETING	1999	854			43	43	93	3
4	DRAPES	1999	585			29	29	63	4
5	NEW ROOF	2000	58,000			2,900	2,900	4,592	5
6	SINK PROJECT	2000	891			45	45	71	6
7	CONTROL HEAD	2000	523			26	26	37	7
8	TUCKPOINTING	2000	14,500			725	725	1,027	8
9	FUEL TANK	2000	1,133			57	57	76	9
10	PAINTING	2000	7,000			350	350	467	10
11	PAINTING	2000	3,350			168	168	224	11
12	CLOSET DOORS	2000	2,250			113	113	151	12
13	CLOSET DOORS	2000	1,500			75	75	100	13
14	CLOSET DOORS	2000	1,250			63	63	84	14
15	PAINTING	2000	9,000			450	450	563	15
16	CUBICLE CURTAINS	2000	2,688			269	269	538	16
17	DOOR FRAME	2000	1,200			120	120	210	17
18	CLOSETS/DOORS	2000	6,717			672	672	1,064	18
19	DOOR CLOSURE	2000	3,250			325	325	515	19
20	CLOSETS/DOORS	2000	560			56	56	89	20
21	COMPRESSOR	2000	2,437			244	244	366	21
22	SWITCH SYSTEM	2000	4,882			488	488	691	22
23	DOOR	2000	628			63	63	89	23
24	FIRE ALARM CABINET	2000	1,090			109	109	136	24
25	HOOD SYSTEM	2000	685			69	69	81	25
26	ADT SECURITY SERVICE	2001	4,051			152	152	152	26
27	VOICE MAIL SYSTEM	2001	997			33	33	33	27
28	FRIG AC	2001	660			22	22	22	28
29	LANDSCAPE	2001	959			28	28	28	29
30	FRIG A/C	2001	565			16	16	16	30
31	ELEVATOR REPAIRS	2001	717			15	15	15	31
32	PLUMBING	2001	500			10	10	10	32
33	FIRE PANEL	2001	5,600			117	117	117	33
34	TOTAL (lines 1 thru 33)		$ 2,844,962	$ 71,143		$ 89,318	$ 18,175	$ 1,261,151	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,844,962	$ 71,143		$ 89,318	$ 18,175	$ 1,261,151	1
2	PLUMBING	2001	500			6	6	6	2
3	PLUMBING	2001	500			4	4	4	3
4	PLUMBING	2001	1,916			47	47	47	4
5	AIR CONDITIONER	2001	585			14	14	14	5
6	PLUMBING	2001	632			15	15	15	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,095	$ 71,143		$ 89,404	$ 18,261	$ 1,261,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,849,095	$ 71,143		$ 89,404	$ 18,261	$ 1,261,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,095	$ 71,143		$ 89,404	$ 18,261	$ 1,261,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,849,095	$ 71,143		$ 89,404	$ 18,261	$ 1,261,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,095	$ 71,143		$ 89,404	$ 18,261	$ 1,261,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,849,095	$ 71,143		$ 89,404	$ 18,261	$ 1,261,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,095	$ 71,143		$ 89,404	$ 18,261	$ 1,261,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,849,095	$ 71,143		$ 89,404	$ 18,261	$ 1,261,237	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,849,095	$ 71,143		$ 89,404	$ 18,261	$ 1,261,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6				1996	33,314	854	35	952	98	4,839	6
7											7
8											8
	Improvement Type**										
9	CCI ALLOCATION			2001	95	12	20	2	(10)	2	9
10	CCI ALLOCATION			2000	40	1	20	2	1	4	10
11	CCI ALLOCATION			1999	597	15	20	30	15	86	11
12	CCI ALLOCATION			1998	246	6	20	12	(6)	45	12
13	CCI ALLOCATION			1997	3,494	62	20	193	131	1,127	13
14	CCI ALLOCATION			1996	3,841	51	20	203	152	796	14
15	CCI ALLOCATION-INDIANA			1997	405	94	20	17	(77)	57	15
16	CCI ALLOCATION			1994	-	11	20		(11)	-	16
17	CCI ALLOCATION			1993	-	3	20		(3)	-	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 42,032	$ 1,109		$ 1,411	$ 290	$ 6,956	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 460,224	$ 61,763	$ 36,386	$ (25,377)		$ 250,041	71
72	Current Year Purchases	24,513	286	2,785	2,499		2,785	72
73	Fully Depreciated Assets	258,252					258,252	73
74								74
75	TOTALS	$ 742,989	$ 62,049	$ 39,171	$ (22,878)		$ 511,078	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	CCI ALLOCATION			$ 16,109	$ 2,465	$ 2,470	$ 5	10	$ 7,948	76
77										77
78										78
79										79
80	TOTALS			$ 16,109	$ 2,465	$ 2,470	$ 5		$ 7,948	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,637,492	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	135,657	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	131,045	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(4,612)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,780,263	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated to CCI				3,674			5
6								6
7	TOTAL				$ 3,674 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 6,903 Description: Copier-$1608 Time Clock-$1564 Postage Meter-$356 Water Cooler-$608 CCI Alloc.-$2767
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 61,613	$		$ 61,613	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,528			6,528	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			65,299			65,299	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				59,848		59,848	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						36,474		36,474	13
14	TOTAL			$		$ 133,440	$ 96,322		$ 229,762	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,833	$	1
2	Cash-Patient Deposits	32,098		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,128,286		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	120,071		6
7	Other Prepaid Expenses	14,456		7
8	Accounts Receivable (owners or related parties)	50,105		8
9	Other(specify): See supplemental schedule	47,339		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,398,188	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,417		13
14	Buildings, at Historical Cost	2,069,821		14
15	Leasehold Improvements, at Historical Cost	806,047		15
16	Equipment, at Historical Cost	787,061		16
17	Accumulated Depreciation (book methods)	(1,923,848)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	3,393		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,769,891	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,168,079	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 407,671	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,938		28
29	Short-Term Notes Payable	387,947		29
30	Accrued Salaries Payable	158,169		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,337		31
32	Accrued Real Estate Taxes(Sch.IX-B)	149,071		32
33	Accrued Interest Payable	11,560		33
34	Deferred Compensation	1,487		34
35	Federal and State Income Taxes	5,600		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	152		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,165,932	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	970,441		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 970,441	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,136,373	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,031,706	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,168,079	$	48

***(See instructions.)**

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 944,613	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 944,613	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	374,866	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(287,773)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 87,093	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,031,706	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,882,803	1
2	Discounts and Allowances for all Levels	(654,497)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,228,306	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	609,540	6
7	Oxygen	4,523	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 614,063	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	75,691	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,638	19
20	Radiology and X-Ray	990	20
21	Other Medical Services	89,549	21
22	Laundry	4,969	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 178,837	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,547	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,547	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	95,194	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 95,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,120,947	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	915,381	31
32	Health Care	1,921,371	32
33	General Administration	1,221,210	33
	B. Capital Expense		
34	Ownership	384,961	34
	C. Ancillary Expense		
35	Special Cost Centers	229,793	35
36	Provider Participation Fee	73,365	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,746,081	40
41	**Income before Income Taxes (line 30 minus line 40)****	374,866	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 374,866	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,208	1,282	33,041	25.77	2
3	Registered Nurses	6,932	7,899	198,319	25.11	3
4	Licensed Practical Nurses	23,650	26,269	493,148	18.77	4
5	Nurse Aides & Orderlies	74,250	87,793	843,094	9.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,560	2,774	28,307	10.20	8
9	Activity Director	1,952	2,120	27,499	12.97	9
10	Activity Assistants	7,351	7,916	53,587	6.77	10
11	Social Service Workers	3,692	4,218	49,210	11.67	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,283	33,907	14.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,267	19,270	154,017	7.99	15
16	Dishwashers					16
17	Maintenance Workers	3,497	4,039	58,487	14.48	17
18	Housekeepers	21,574	23,638	191,734	8.11	18
19	Laundry	6,984	7,778	66,595	8.56	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,637	8,738	101,719	11.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	678	719	14,170	19.71	33
34	TOTAL (lines 1 - 33)	181,184	206,737	$ 2,346,834 *	$ 11.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	225	$ 13,984	01-03	35
36	Medical Director	Monthly	5,444	09-03	36
37	Medical Records Consultant	Monthly	5,054	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,125	10-03	39
40	Physical Therapy Consultant	96	4,927	10a-03	40
41	Occupational Therapy Consultant	61	2,986	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	400	10a-03	43
44	Activity Consultant	48	2,304	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	CCI Allocation (See Attached)		72,447		48
49	TOTAL (lines 35 - 48)	438	$ 108,671		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	55	$ 1,838	10-03	50
51	Licensed Practical Nurses	142	3,676	10-03	51
52	Nurse Aides	780	12,865	10-03	52
53	TOTAL (lines 50 - 52)	977	$ 18,379		53

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrators Salary paid through Care Centers			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Eric Rothner Management Fees	$ 71,204
Noah Wolff Management Fees	71,204
CCI Administrative Payroll	74,111
TOTAL (agree to Schedule V, line 17, col. 3)	$ 216,520
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 2,067
FR&R	Accounting	25,162
Maxxsource	Data Processing	2,155
Alpha Data	Data Processing	3,898
Neal Gerber	Legal	42,832
Winston & Strawn	Legal	603
Crowe Chizek	Accounting	678
American Express Tax Service	Accounting	180
M. Cohen	Management Consultant	2,045
Care Centers Inc.	See Attached	193,643
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 273,262

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,981
Unemployment Compensation Insurance	18,415
FICA Taxes	179,533
Employee Health Insurance	57,043
Employee Meals	15,914
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	448
Pension Plan	4,116
Misc Employee Welfare	8,200
Employee Drug Testing	1,570
TOTAL (agree to Schedule V, line 22, col.8)	$ 356,220

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	6,193
Health Care Worker Background Check	
(Indicate # of checks performed 141)	1,692
Yellow Page Advertising	2,217
Licenses & Fees	2,991
Dues & Subscriptions	4,904
Advertising & Promotion	25,363
CCI Allocation	1,342
Less: Public Relations Expense	
Non-allowable advertising	(25,363)
Yellow page advertising	(2,217)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,322

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,781
Education Expense	564
Allocated from CCI	974
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,319

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Il Council on LTC - $5,424.32**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,687** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **73,365**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,914** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees